Must be Received by June 30, 2015 to Remain on the Program

END STAGE RENAL DISEASE PROGRAM

2015 Confidential Eligibility Review

APPLICANT'S INFORMATION

Name _____
Last First MI

Physical Address _____
Number/Street/Apt. City State ZIP Code

Mailing Address _____
Number/Street/Apt/PO Box City State ZIP Code

Birth Date _____ Gender: Male / Female

Telephone Number ( ) _____

Number of persons in household _____ Relationship to applicant _____

APPLICANT'S PERSONAL INCOME	ALL OTHER HOUSEHOLD'S PERSONAL INCOME
Employer / Occupation _____	Employer / Occupation _____
City/State _____	City/State _____
Gross Earnings from Employer $_____	Gross Earnings from Employer $_____
Monthly Social Security $_____	Monthly Social Security $_____
Monthly Retirement Income $_____	Monthly Retirement Income $_____
Monthly Disability Income and Source $_____ _____	Monthly Disability Income and Source $_____ _____
Monthly Income any other Source $_____	Monthly Income any other Source $_____
Total Gross Income Last Year $_____	**Total Gross Income Last Year $_____**
➔ **Attach a Filed Copy of your 2014 Income Tax Return along with proof of Social Security Benefits. If you do not file an income tax return, include a letter of explanation.**	➔ **Attach a Filed Copy of your 2014 Income Tax Return along with proof of Social Security Benefits. If you do not file an income tax return, include a letter of explanation.**

BUSINESS, FARM, OR OTHER INCOME	Amount $
Yearly Farm or business Income (if listed, please attach an itemized statement of business income and expenditures).	
Yearly Income from any sources other than shown above (rental property you own, dividends, welfare, unemployment compensation, per capita payments, part – time job, second job, child support, etc.).	

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2015 FINANCIAL DATA

Monthly Medical Expenses

Applicant's Medical Payments (ESRD Related Only)

	Monthly Payment	Balance Owed
Physician		
Hospital		
Dental		
Prescriptions		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		

Assets (Applicant and Spouse)

Estimated Market Value of Home	
Value of Other Real Estate	
Stocks and/or bonds (name and value)	
Name of Bank	
Amount in Savings	
Amount in Checking	
Farm or business equipment value	
Other Assets (Type and Value)	
Other Assets (Type and Value)	

I (Applicant)_____ am renewing my application for assistance from the End Stage Renal Disease Program. I am unable to pay for the recommended treatment. I will apply any hospital and or medical insurance and Medicare and/or Medicaid benefits I receive to the cost of my care. I will pay Medicare and/or Medicaid and other insurance premiums to provide coverage. I understand that the End Stage Renal Disease Program must give prior authorization for any care for which it is to pay.

All information I have given on this confidential eligibility review and my original application is true and correct to the best of my knowledge.

Signed: _____Date_____

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2015 Health Insurance Update

A. **Do you have private health insurance?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your insurance cards.

Health Insurance Company Name	Type of Coverage	Effective Date	Policy Number
Monthly Premiums **(Applicant only)**	**$**		

B. **Do you have Medicare coverage?** ☐ Yes ☐ No If yes, please complete the following information and attach a copy of your Medicare card.

Type of Coverage (check each box that applies)	Effective Date	Medicare ID Number
Part A ☐ Part B ☐ Part D ☐		
Monthly Premiums	Part B **$**	Part D **$**

C. **Do you have Medicaid coverage?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your Medicaid card.

Type of Coverage	Effective Date	Medicaid ID Number

D. **Do you have Indian Health Service coverage?** ☐ Yes ☐ No

Dialysis Center Information

Please complete the information below as verification you are currently receiving dialysis treatments. **Transplant clients-enter the information for transplant clients only.**

Dialysis Center Name:			
Address:			
City:	**State:**	**Zip:**	
Social Worker Name:			
SW Phone Number:			
SW E-Mail:			
TRANSPLANT CLIENTS ONLY			
Transplant Date:			

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CHECK LIST

HAVE YOU:

- ☐ **Filled out the eligibility review completely;**
- ☐ **Signed and dated your eligibility review;**
- ☐ **Included a photocopy of your 2014 income tax return OR a letter of explanation as to why there is no 2014 income tax return (no form letters will be accepted);**
- ☐ **Included proof of income for your entire household;**
- ☐ **Included current Social Security Benefit Letters for entire household;**
- ☐ **Included photocopies of all your health coverage identification cards;**
- ☐ **Completed your dialysis center or transplant information;**
- ☐ **Included your physical address along with your mailing address?**

Your eligibility review must include the above information to be complete. If your review is incomplete, it will be returned to you.

Your benefits will lapse if a complete eligibility review is not received by June 30, 2015.

If you have questions, please see your social worker or contact ESRD at 307-777-3527 or cherame.serrano@wyo.gov.

State of Wyoming Department of Health
End Stage Renal Disease Program
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Wyoming Department of Health
Commit to your health.